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AUTHOR Bradley, Curtis H.; Sandiford, Janice
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ABSTRACT

These materials for a workshop, designed to help health occupations education teachers develop the interpersonal skills necessary to improve their teaching, consist of two conference reports, a minilecture, and a workshop exercise. The first report, which is entitled "Interaction Analysis for Health Occupations Education Teachers," contains an explanation of the Flanders Interaction Analysis System (FIAS), an outline of an expanded version of the system, and a discussion of its application in health occupations education. The second report, entitled "Interpersonal Communication for Health Occupations Education: A Microcounseling Approach," includes a discussion of the following topics: the skills of microcounseling (attending behavior, open questions, minimal encouragement to talk, reflection of feeling, paraphrasing, and summarization), how microcounseling works, and a sample microcounseling group exercise. A microcounseling minilecture, a skills exercise covering an open invitation to talk, and an interaction analysis miniworkshop evaluation form follow. (MN)

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ED200744

INTERPERSONAL SKILLS

FOR

HEALTH OCCUPATIONS EDUCATION

Curtis H. Bradley, Ed.D.

Janice Sandiford, Ph. D.

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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Introduction

Teacher-student interaction in the classroom often goes unnoticed in the attempt of the teacher to deliver the facts. Such is true in the health occupations education classroom, as in other classrooms, where the amount of knowledge necessary for the student to be able to funtion safely is excessive. Learning can occur in ways other than students listening to teachers lecture. Teachers can deliver instruction in many ways which increases student participation. Interaction analysis helps teachers develop insight into their own pattern of influence through objective data by being aware of teacher-student interaction. It also assists teachers in becoming more purposeful in the delivery of instruction and creating a learning atmosphere that increases the freedom of the student to respond.

After the teacher has gained insight into the impact of his or her teaching performance on the learning environment, a method is needed to help the teacher develop the interpersonal skills needed to change his or her teaching, if desired. Microcounseling is an effective method for the development of these interpersonal skills. In addition, microcounseling has the additional value of being a method that the health occupations education teacher can use to help his or her student develop more effective interpersonal skills.

The materials which follow were prepared for this workshop held April 2, 1981, in Orlando, Florida, to introduce health occupations education teachers to interaction analysis and mocrocounseling.

TECHNIQUES FOR TEACHING COMMUNICATION SKILLS

Sponsored by

Health Occupations Educators Association of Florida
and
Department of Education, Division of Health and Public Service

Thursday April 2, 1981

9:30		Registration and coffee
10:00	- 10:30	Welcome and introductions
		Introduction to Damon Instructional System Joe Di Stefano
10:30	- 11:45	An introduction to Interaction Analysis
11:45	- 1:00	Lunch on your own
1:00	- 3:00	Learning the categories of Interaction Analysis Practice using the categories of Interaction Analysis Application to Vocational Education - Health Occupations
3:00	- 3:15	Break
3:15	- 4:45	Microcounseling and Human Relations/Creativity Training
4:45	- 5:00	Wrap-up, conclusions, evaluation, announcements

Objectives:
At the conclusion of this workshop, the participant will be able to:

- *Define Interaction Analysis and state how IA will be useful in his/her own setting*
- *Use Interaction Analysis*
- *Define microcounseling and state how it can be useful in his/her own setting*
- *Describe human relations/creativity training approach*

Faculty:
Dr. Curtis H. Bradley
Dr. Janice R. Sandiford

REFRESHMENTS COMPLIMENTS OF DON JAEGER CORPORATION
AND
THE DAMON INSTRUCTION SYSTEM
Don Jaeger and Joe DiStefano

Note: 6 contact hours will be awarded this workshop

Continuing Education

H.O.E.A.F. has been approved by the Florida Board of Nursing as a Continuing Education provider for nurses, Provider # 27MO562

EXHIBITS OPEN 10 - 5

Program and Planning Committee - Dr. Janice Sandiford, Chairperson
Martha Bell, Reeda Fullington, Suzanne Hammersburg, Mary Lou Park

Interaction Analysis for Health Occupations Education Teachers

Teachers often perform their duties caught up in an attempt to deliver subject matter to students giving thought to their teaching style. Health occupations education teachers are no different, often they teach alone without an opportunity to have their teaching style observed by a peer, nor time to even give teaching style a thought. Even when a supervisor observes the teacher, the observation is intended to be used as a part of evaluation and rarely descriptive of teaching style.

Should teaching style and the interaction which occurs as a result of teaching style be as important to the teacher as the content of the lesson? Should the teacher be aware of their teaching style and be purposeful in the delivery of lesson content? It is the premise of this paper that they should.

Flanders Interaction Analysis System (FIAS) is a widely known and frequently used method of recording and analyzing the student-teacher verbal interaction in the classroom. FIAS provides a systematic, objective method for teachers to become more aware of their influence on the class and to make their own judgments regarding adjusting that influence. However, the interaction in many classrooms, such as health occupations, is atypical of that found in general education classes. Thus,

FIAS is an effective tool, but one that is not tailor-made to record and analyze the unique interaction found in a number of teaching-learning environments.

The different interaction found in most health occupations education programs is often such a nature as to be inadequately, or even improperly described by the traditional categories of FIAS. Investigators in other fields of education have arrived at similar conclusions. Dougherty (1970) and Cheffers (1973), for instance, found it necessary to modify FIAS to adequately record and analyze interaction in physical education classes. Moskowitz (1968) expanded FIAS for foreign language education classes. FIAS has even been expanded for utilization with microteaching (Amidon, et. al., 1969). Traditional FIAS has been expanded (Bradley, 1973; Bradley and Amidon, 1978) within the field of vocational education to record more accurately the interaction found in the vocational education laboratory or classroom. This expansion can be specifically applied in health occupations education programs.

The FIAS System

FIAS classifies all teacher statements into the general subdivisions of either "indirect" or "direct" influence. This separates teacher verbal behavior into those statements which maximize student freedom to respond (indirect) from those statements which minimize the freedom of student response

(direct). These two subdivisions of teacher statements or "teacher talk" are further divided into seven of the categories shown in Figure 1.

Insert Figure 1 here

"Student talk", as shown in Figure 1, is subdivided into either Category 8 Response (teacher initiated student statements) or Category 9 Initiation (student initiated statements). FIAS reveals not only the ratio of teacher talk to student talk, but also the percentage of student talk that is teacher initiated - 'telling us just what we want to hear'. Other information such as the emphasis given to motivation and control, type of teacher response to student comment, the kind of teacher statements that tend to stimulate student talk, etc. is obtained from an analysis of the data recorded using FIAS. It must be emphasized, however, that FIAS does not make value judgments regarding teacher behavior and is not intended to be an evaluation of "good" or "bad" teaching style but merely to help teachers understand their particular style. Every category of teacher behavior in FIAS clearly belongs in the repertoire of every teacher for use at the appropriate time. FIAS provides feedback that affords the opportunity to gain insight into patterns of influence. The understanding gained from

this insight may well cause teachers to want to modify teaching behavior in order to achieve their goals. A decision to modify behavior is made by the teacher, it is not decreed or even recommended as a value judgment of FIAS.

The final category (10) is "Silence and Confusion". This category is used when it is difficult to determine who is talking, or when the classroom activity is non-verbal. This is the only FIAS category available to record psychomotor activity.

An observer, or the teacher utilizing audio or videotape feedback, uses these ten categories to record and later analyze the verbal interaction in a classroom. The procedure for recording and analyzing the data will not be reviewed here. Interested readers are referred to Amidon and Flanders (1971).

The Expanded System

Being designed to record and analyze verbal behavior, psychomotor skill activities of the teacher and/or student cannot be properly or accurately recorded. When the teacher is giving a demonstration interspersed with questions and comments, and/or student practice, as is the case in many health occupations classrooms, the knowledge of the impressions and effects upon the student developed by the demonstration is lost in an inappropriate category. The knowledge of the impressions and effects upon the student developed during the demonstration is

as important to the teacher as the student effects resultant from verbal behavior.

An additional consideration is that of correcting student practice of psychomotor skills. If the teacher's verbal behavior is designed to "change student behavior from nonacceptable to acceptable ...." it would be recorded as Category 7 (Figure 1) criticizing or justifying authority. This would not appear to be an accurate categorization of that interaction. Although ground rules are established to deal with this complexity (Amidon and Flanders, 1971) this interaction of the understanding teacher attempting to help a student improve performance of a psychomotor skill is mis-classified.

Because of the diminished capacity of the validity of categorizing activities as discussed in Cheffers (1972) when psychomotor activities are occurring in the classrroom, the addition of the following three subdivisions makes FIAS more viable for the typical health occupations classroom. These subdivisions were suggested (Bradley, 1973), with full awareness that the simplicity of FIAS is one of its strengths.

(5 A) Demonstrations: Showing methods, procedures and techniques.

(7 A) Corrections: Showing or telling students how to improve their practice or understanding of a skill (as opposed

to censure or sarcasm).

(8 A) Practice: Student practice of skills or procedures.

The categories for application of interaction analysis as suggested by Bradley (1973) are shown in Figure II, Interaction Analysis for Vocational Educators (IAVE).

Insert Figure II here

The new subdivisions require the use of a 13 x 13 matrix for interpretation, rather than the 10 x 10 FIAS matrix and increases the complexity somewhat but moves toward increasing the validity and reliability of FIAS when applied to activities involving psychomotor skills.

Application in Health Occupations Education

Interaction analysis is an excellent source of systematic feedback for any teacher. As modified, IAVE becomes appropriate for use in the health occupations education classroom to help the health occupations education teacher analyze his/her teaching style. The health occupations education teacher frequently uses demonstrations, corrections and practice activities in the helpful process of showing or telling students how to improve their skills. Without the use of these subdivisions, teaching activity of the health occupations education teacher

would be inappropriately or inaccurately classified as sarcasm, bawling out, silence or confusion, which it is not.

The value of an interaction analysis system modified for health occupations education is demonstrated by a comparison of the results of encoding the same lesson using first the traditional FIAS then using IAVE. A five minute videotaped session from a workshop was selected. The lesson consists of a teacher explaining and demonstrating how to apply sterile gloves, followed by student practice. A few closed questions were used.

Figure III is the matrix obtained from encoding this microlesson using the FIAS method. This matrix indicates that 30% of the lesson was spent in "Silence and Confusion" (Column 10), the only FIAS category available for recording non-verbal interaction. It would appear also that only 13% of this lesson involved student participation (Columns 8 and 9, and that 3% of the lesson was spent in criticizing or justifying authority (Column 7).

Insert Figure III here

Figure IV is the matrix derived from the same microlesson using Interaction Analysis for Vocational Education (IAVE). This matrix shows that only 1% of the lesson was spent in

"Silence and Confusion". In addition, 31% of this lesson involved active student participation (IAVE Categories 8, 8A and 9). Indeed, 40% of the lesson involved teacher demonstration (IAVE Category 5A) and student practice (IAVE Category 8A) which cannot be described by the data on the FIAS matrix.

Insert Figure IV here

Many additional observations can be made by analyzing the individual cells of each matrix. The differences would be even more pronounced in the entries recorded during a full length lesson. The necessity for expanding FIAS to make it appropriate for health occupations education is obvious. Psychomotor activity, whether performed by the teacher or the student, must be accurately recorded. Coding all psychomotor activity as "Silence or Confusion" provides inaccurate as well as inadequate feedback and as such it fails to serve its purpose. In addition, FIAS requires that teacher statements designed to help the student change psychomotor activity performance must be classified in the same category (7) as "bawling someone out", or (6) "directions, commands, or orders". Neither of these categories accurately describe the helpful process of showing or telling a student how to improve his/her skills. Thus the special interaction of the health occupations

education laboratory or classroom requires a unique method of categorizing interaction. Further discussion of Interactional Analysis for Vocational-Technical Education can be found in Bradley and Amidon (1978).

Summary

Interaction Analysis for Vocational Education (IAVE) appears to expand FIAS to provide the breadth of categories required to accurately analyze the unique student-teacher interaction found during lessons involving psychomotor activities, as occurs in the health occupations education classroom. To thoroughly learn to use this system, more formal training such as a college course, workshop or a self-instructional program (Bradley & Amidon, 1978) is generally required. Even without intensive training, the health occupations education teacher could effectively begin to determine their teaching style by recording a few mini-lessons and analyzing the interaction which occurs using the IAVE matrix and taking advantage of the wealth of material and experience developed through FIAS. Becoming a more effective teacher, generating enthusiasm and being able to control the interaction which occurs in the classroom to increase the learning of students should be equally as important as the content of the lesson. Using IAVE could be a step in the right direction to determining your teaching style and becoming a more effective teacher.

Figure I

CATEGORIES FOR INTERACTION ANALYSIS

TEACHER TALK	INDIRECT INFLUENCE	1. *ACCEPTS FEELING: Accepts and clarifies the feeling tone of the students in a nonthreatening manner. Feelings may be positive or negative. Predicting or recalling feelings is included. 2. *PRAISES OR ENCOURAGES: Praises or encourages student action or behavior. Jokes that release tension, but not at the expense of another individual; nodding head, or saying "um hm?" or "go on" are included. 3. *ACCEPTS OR USES IDEAS OF STUDENTS: Clarifies, builds, or develops ideas suggested by a student. As teacher brings more of his own ideas into play, shift to Category 5. 4. *ASKS QUESTIONS: Asks a question about content or procedure with the intent that a student answer.
	DIRECT INFLUENCE	5. *LECTURES: Gives facts or opinions about content or procedures; expresses own ideas, asks rhetorical questions. 6. *GIVES DIRECTIONS: Directs, commands, or gives orders with which a student is expected to comply. 7. *CRITICIZES OR JUSTIFIES AUTHORITY: Statements intended to change student behavior from nonacceptable to acceptable pattern; bawls someone out; states why the teacher is doing what he is doing; extreme self-reference.
STUDENT TALK		8. *STUDENT TALK-RESPONSE: A student makes a predictable response to teacher. Teacher initiates the contact or solicits student statement and sets limits to what the student says. 9. *STUDENT TALK-INITIATION: Talk by students, which they initiate. Unpredictable statements in response to teacher. Shift from 8 to 9 as student introduces own ideas.
		10. *SILENCE OR CONFUSION: Pauses, short periods of silence, and periods of confusion in which communication cannot be understood by the observer.

*There is NO scale implied by these numbers. Each number is classificatory; it designates a particular kind of communication event. To write these numbers down during observation is to enumerate—not to judge a position on a scale.

Figure 2

CATEGORIES OF INTERACTION ANALYSIS FOR VOCATIONAL EDUCATION

TEACHER TALK

INDIRECT INFLUENCE

*1. ACCEPTS FEELING: Accepts and clarifies the feeling tone of the students in a nonthreatening manner. Feelings may be positive or negative. Predicting or recalling feelings is included.

*2. PRAISES OR ENCOURAGES: Praises or encourages student action or behavior. Jokes that release tension, but not at the expense of another individual; nodding head, or saying "um hum?" or "go on" are included.

*3. ACCEPTS OR USES IDEAS OF STUDENTS: Clarifies, builds, or develops ideas suggested by a student. As teacher brings more of his own ideas into play, shift to Category 5.

*4. ASKS QUESTIONS: Asks a question about content or procedure with the intent that a student answer.

DIRECT INFLUENCE

*5. LECTURES: Gives facts or opinions about content or procedures; expresses own ideas, asks rhetorical questions.

*5A DEMONSTRATES: Shows methods, procedures, and techniques.

*6. GIVES DIRECTIONS: Directs, commands, or gives orders with which a student is expected to comply.

*7. CRITICIZES OR JUSTIFIES AUTHORITY: Statements intended to change student behavior from nonacceptable to acceptable pattern; bawls someone out; states why the teacher is doing what he is doing; extreme self-reference.

*7A CORRECTS: Shows or tells a student how to improve his practice or understanding of a skill. (If sarcasm or censure are involved, code Category 7, not 7A.)

STUDENT TALK

*8. STUDENT TALK-RESPONSE: Talk by students in response to teacher. Teacher initiates the contact or solicits student statement.

*8A PRACTICE: Student practice of skills or procedures.

*9. STUDENT TALK-INITIATION: Talk by students, which they initiate. If "calling on" student is only to indicate who may talk next, observer must decide whether student wanted to talk. If he did, use this category.

*10. SILENCE OR CONFUSION: Pauses, short periods of silence, and periods of confusion in which communication cannot be understood by the observer.

*There is no scale implied by these numbers.

Figure 3

Matrix of a Microlesson using Flanders Interaction Analysis System

	1	2	3	4	5	6	7	8	9	10	
1											
2		2	1	2		2				1	
3			2							1	
4				5				4			
5		1		1	19	1			1	1	
6					1	7				3	
7						1	2				
8		3			1			6			
9		1							2		
10		1		1	1	1	1			24	Matrix Total
Total	—	8	3	9	22	12	3	10	3	30	100
%	0	8	3	9	22	12	3	10	3	30	

Figure 4

Matrix of Same Microlesson Using Interaction Analysis for Vocational Education

	1	2	3	4	5	5A	6	7	7A	8	8A	9	10	
1														
2		2	1	2	1		1						1	
3			2			1								
4				5						4				
5		1			8	2						1		
5A				2	1	17	2							
6						2	7				2			
7														
7A							1		2					
8		3			1					6				
8A		1							1		16			
9		1										2		
10					1									Mit. Tot
Total	—	8	3	9	12	22	11	-	3	10	18	3	1	10(
%	0	8	3	9	12	22	11	0	3	10	18	3	1	

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Interpersonal Communication for Health Occupations Education: A Microcounseling Approach

Individuals who teach in the health occupations are certainly aware of the need for effective interpersonal skills on the part of their students. Exciting innovations such as videotape modules and role-playing are often incorporated into the health occupations education classroom. Useful as these innovations may be, however, interpersonal communication often remains something of a "mystical art" to the student. The problem is not so much the difference between simulation and the real works, but rather the lack of concrete definition of the components of effective interpersonal communication.

Consider for example, the student's first meeting with a patient. This initial meeting with an actual patient can be a rewarding or devastating experience for the young student. Effective interpersonal skills are essential to a successful experience. The student generally "understands" that he or she is to listen intently, convey interest, ask questions for a variety of reasons, and so on. But what do these concepts mean in fact to the student? How does one listen? How does one individual convey to another that he or she is listening and interested? What types of questions will cause the patient to give limited responses, what type cause the patient to respond more fully? Specific answers to these questions must be known

to the student and be operationalized as part of the student's behavioral repertoire; application and mastery of hazy concepts is paradoxical.

A health occupations education program designed to develop effective interpersonal communication skills must define the related concepts in operational terms and provide a systematic technology for their application and mastery. Microcounseling has transformed the "mystical art" of interpersonal skills into concrete form through behavioral definition of discreet, identifiable behaviors and a system technology. This article describes microcounseling and suggests that the technology of microcounseling makes possible the development of effective interpersonal skills for every health occupations student.

The Skills of Microcounseling

A number of skills have been identified and field-tested within the microcounseling framework (Ivey, 1971; Ivey and Authier, 1978). These twelve skills are organized into a number of broad categories or skill clusters; interviewing, listening, interpretation and the beginning skills of interviewing: the skills of attending behavior, open questions and minimal encourages to talk. These skills help the learner to convey interest as well as to get the other person to talk and to express him or herself more fully. These skills enable the learner to avoid early attempts at interpersonal communication

being disastrous. Although basic, these skills are essential for every person entering the work world. Indeed, experienced supervisors and teachers also benefit from and welcome systematic microcounseling training in these basic constructs.

Another cluster consists of selective listening skills including reflection of feeling, paraphrasing and summarization. These skills enable the learner to communicate understanding of affect as well as content of the other person's words. These skills also assure that both parties have the same understanding of what is being said. The need for these skills in numerous situations is obvious. An advanced category consists of interpretation skills and is primarily used by individuals with advanced training.

The health occupations education teacher may not consider every microcounseling skill appropriate to the needs of health occupations education students. That is as it should be. Microcounseling is an open system. The health occupations education teacher is encouraged to select those skills considered to be most important in a particular setting, or even develop definitions of new skills. Regardless of the specific skills considered most appropriate for effective functioning, the systematic technology of microcounseling may be utilized efficiently.

One health occupations education teacher may consider at-

tending behavior as a critical need of all students preparing for a health occupations career and incorporate attending behavior into the curriculum via microcounseling. Another teacher might determine to include selective listening skills as well as attending behavior. Each teacher could also elect to modify the existing microcounseling skill manuals to identify his or her own style. Each would have an individualized yet systematic approach to teaching the concrete behaviors that he or she has identified as essential.

How Microcounseling Works

Judy was role-playing her part in a simulated initial meeting with a patient. The meeting was being videotaped. After the initial greeting, which was very cordial, Judy became visibly tense. She stood frozen in a rigid position, except for her eyes which wandered everywhere except toward the patient. As the meeting progressed, the patient did all that she could to help Judy relax, but Judy was so intent upon "what she was supposed to say" that she could not relax and communicate with the patient. Judy is normally a warm and outgoing young lady and no stranger to the video camera, yet under the pressures of this meeting, she conveyed an image of confusion, perhaps even of disinterest. Hardly a good beginning to her relationship with this patient.

At the conclusion of the videotaped interview, Judy was

given the microcounseling manual Attending Behavior (Ivey & Gluckstern, 1974) to read. This manual clearly describes the three components of attending behavior: good eye contact, verbal following and relaxed physical posture. Reading of the manual was followed by viewing of a videotape model of a former student expertly demonstrating attending behavior. Judy and her teacher then viewed and discussed Judy's videotaped interview. Judy then participated in another videotaped interview with the patient wherein she demonstrated improved attending behavior and conveyed real interest and enthusiasm. If Judy or her teacher had not been satisfied with her performance in the second interview, the entire process would have been recycled.

Judy's experience illustrated the basic microcounseling format: 1) Baseline measurement; 2) Training; and 3) Reinterview, and the essential elements of microcounseling. Effective as individual microcounseling sessions are, however, most educators simply do not have sufficient time for the individual one to two hour microtraining session. The group approach to microcounseling is, therefore, more realistic. The group method is most useful to the health occupations education teacher. An example of how this method may be used in the health occupations education classroom follows.

A Sample Microcounseling Group Exercise

Reading about a training program does not provide a truly viable means whereby the busy health occupations education teacher can tell whether or not this framework is meaningful and worthy of inclusion in an already crammed curriculum. Following is a basic workshop suitable for a one-hour class in health occupations education. The workshop assumes one teacher and twenty-four students. The topic is "Listening Skills for the Practical Nurse".

1. Introduction by teacher. Inform the students they are working on basic listening skills for the practical nurse. An important part of being an effective practical nurse is the ability to listen and to hear the other person (whether 'boss', co-worker, patient or visitor). We are working on only one single aspect of interpersonal communication. Don't worry about other dimensions at this time. Focus on just one exercise.
2. Ask for volunteers to role-play a meeting between a practical nurse and a patient being admitted to the hospital. The patient wants to "discuss a problem of a previous hospitalization" and tries hard to communicate with the practical nurse. The practical nurse, on the other hand, is to

exaggerate and do as many things wrong in terms of listening as possible. The class is divided into groups of approximately six each. They observe the role-played interaction (three to five minutes is suitable for making the point) and then make lists of what the practical nurse "did wrong". They discuss and share their lists with the entire class.

3. A mini-lecture by the teacher follows emphasizing attending behavior as demonstrated and discussed in the session with Judy above. Possibly the paragraphs on Judy could be mimeographed and distributed to the students to supplement the lecture.
4. Another role play is held in which the practical nurse does a more effective job. Once again the students observe and note differences between the two sessions.
5. Students then practice this exercise in pairs within their groups so that the concept of attending behavior is experientially learned. It is helpful if a sub-group leader is appointed to encourage full participation (Bradley & Ivey, 1977).

This sample exercise even without videotaping has proven

effective in many settings. Brief, clearly written manuals each describing a specific microcounseling skills are available (Ivey, 1971; Ivey and Gluckstern, 1974) for teachers who wish to try microcounseling with their students.

Effective interpersonal communication is essential to student success in the health occupations. Microcounseling clearly defines specific, observable behaviors that comprise effective interpersonal communication and provides a systematic technology that enables application and mastery of each skill.

The health occupations education teacher is encouraged to selectively use the existing microcounseling skills, modify skills as desired, or even develop new skills to meet specific needs of business education students. Because of the technology of microcounseling, each teacher will have an individualized, yet systematic approach to teaching the concrete behaviors that he or she has identified as essential, but heretofore illusive interpersonal skills.

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Appendix

MICROCOUNSELING MINI-LECTURE #1

Attending Behavior *

The term attending behavior describes specific observable listening skills. Good attending behavior conveys to the other person that you respect him or her as a person and that you are interested in what he or she has to say. Attending behavior is a basic, rather simple skill -- but with many, many profound implications.

Three key dimensions comprise attending behavior:

1. Eye contact. If you are going to talk to someone, look at them. No need to stare, just be aware that you are talking to another person. You'll also want to notice "eye contact breaks" .... when you look away you are sometimes telling the person you are working with that you aren't really with them. Later on, you'll start noticing that eye contact breaks on the part of the other person gives you clues as to where that other person "is at". More on that later.

2. Attentive body language. We usually think that counseling is a verbal relationship. In truth, some estimates say that 85% of our communication is nonverbal. Think for a minute .... how should your body communicate that it is listening? Find your own natural listening style and check with others to see how it "comes across". The basic attentive listening posture in our culture is a slight forward trunk lean with a relaxed, easy posture. BUT FIND YOUR OWN STYLE .... being yourself is most important.

3. Later on you'll want to start looking for small signs of tension (frowns, tense mouth or chin, clenched fists, marked shifts in body posture at key times in the interview) in both yourself and the patient/client. But for now, simply assume a relaxed body position and communicate that you are involved.

4. Verbal following. A frequent basic question of many students is, "What do I say?". We say, don't get uptight, take whatever the patient/client has said and respond to it in a natural way. Direct whatever you may say to what the patient/client has just said or said earlier in your conference. There is no need to talk about yourself when you are attending .... simply stay with what has already been said. In summary, don't topic jump.

* Adapted from Ivey, A. & Gluckstern, N. Basic Attending Skills: Participant Manual. North Amherst, Mass: Microtraining Associates, 1974.

A final point is to respect yourself and the other person. Ask questions or make comments about things that interest and seem relevant to you. If you are truly interested in what is being said, attending behavior often follows automatically. But remember, the more interested you are, the harder it sometimes becomes to keep yourself quiet and <u>listen</u> to the other person.

HELPING CONFERENCE SKILLS

Open Invitation to Talk *

The patient/client wants to talk with you. Your initial goal is to help the client/patient begin to discuss freely those matters that concern him or her. The most useful technique for helping the patient/client begin to talk is called Open Invitation to Talk.

An open invitation to talk can best be understood when compared to a closed approach to interviewing. For example:

Open: Could you tell me a little bit about your problem?
or
How do you feel about.....?

Closed: Are you married?
Do you have any allergies?

It may be observed that open comments provide room for the patient/client to express his or her real thoughts without the imposed categories of the student. An open invitation to talk allows the patient/client to explore with the support of the student. A closed invitation to talk, however, often emphasizes factual content as opposed to feelings, demonstrates a lack of interest in what the patient/client has to say, and frequently attacks or puts the patient/client in his or her place. Closed questions can usually be answered in a few words or with a yes or no.

Crucial to open-ended questions is the concept of who is to lead the conference. While the student does ask questions when using this skill, the questions center around concerns of the patient/client more than concerns of the student. Questions should be designed to help the patient/client clarify his or her own problems, rather than provide information for the student. A typical problem with closed questions is that the student leads the patient/client to topics of interest to the student only. Too often the student projects his or her own theoretical orientation into the information he or she is attempting to gather, imposing artificial structure too early. If the student relies on closed questions to structure the conference, he or she is often forced to concentrate so hard on thinking up the next questions that he or she fails to listen to and attend to the patient-client.

Open invitations to talk are extremely useful in a number of situations. The following are some examples:

*Adapted from Ivey, A. & Gluckstern, N. Basic Attending Skills: Participant Manual. North Amherst, Mass: Microtraining Associates, 1974.

1. They help to begin the conference (How have things been since the last time we talked together?).

2. They help the patient/client to elaborate one point (Could you tell me more about that? How did you feel when that happened?).

3. They help elicit examples of specific behavior so that the student is better able to understand what the patient/client is describing (Will you give me a specific example? What do you mean when you say...).

Go through the examples above again and change each question to a closed question. Now change your closed questions to open ones.

IF I WERE RUNNING THIS SESSION....

I ALSO THINK THIS SESSION WAS:

- ☐ well-planned
- ☐ boring
- ☐ useful
- ☐ a waste of time
- ☐ stimulating
- ☐ interesting
- ☐ unnecessary
- ☐ complete
- ☐ bad
- ☐ unorganized
- ☐ incomplete
- ☐ important
- ☐
- ☐
- ☐
- ☐
- ☐

INTERACTION ANALYSIS MINIWORKSHOP

HEALTH OCCUPATIONS EDUCATORS ASSOCIATION OF FLORIDA
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